AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING O1			(X3) DATE SURVEY COMPLETED	
		155747	B. WING	3 <u> </u>		09/19/	2012
	PROVIDER OR SUPPLIER			1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
K0000	State Licensure Assurance Wal conducted by t Department of accordance wit Survey Date: O Facility Numbe Provider Numb AIM Number: Surveyor: Amy Code Specialist At this Life Saf Woodcrest Nur found not in co Requirements Medicare/Medi Subpart 483.70	k-thru Survey were the Indiana State Health in th 42 CFR 483.70(a). 19/19/12 r: 000556 ter: 155747 100290130 r Kelley, Life Safety t t tety Code survey, sing Center was compliance with for Participation in	K00	00	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Woodd Nursing Center maintains that alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are to of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Woodcrest Nurs Center asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety	e rest the ne they e	
	the National Fi				constitutes this provider's allegation of compliance and,		
		FPA) 101, Life Safety			thereby, we request resurvey		
		I 410 IAC 16.2. The			verify such as of October 19 th 2012.	١,	
	original section	n of the building					
	consisting of A	Wing, C Wing, the			Further, v	ve	
	Extended Care	Wing and the main			request desk review (paper compliance) for compliance, if acceptable.		
	dining room w	as surveyed with					
	Chapter 19, Ex	isting Health Care			ασσεριανίε.		
	Occupancies.	-			Completion	1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	01	COMPLI	ETED
		155747	B. WIN			09/19/	2012
			b. wii		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ERCER AVE		
WOODC	REST NURSING (CENTER			UR, IN 46733		
				<u> </u>	G. X, 10700		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATOR FO	R ESC IDENTIFTING INFORMATION)	+	IAU	<u> </u>	ırol	DATE
					dates are provided for procedule processing purposes to comp		
	This one story	facility was			with federal and state regulation	-	
	determined to	be of Type V (111)			and correlate with the most re-		
	construction a	and was fully			contemplated or accomplished	d l	
	sprinklered.	The facility has a fire			corrective action. These do no	t	
	alarm system	<u>-</u>			necessarily chronologically		
	<u> </u>	orridors, areas open			correspond to the date that Woodcrest Nursing Center is		
		rs with hard wired			under the opinion that it was in	,	
		ors in the resident			compliance with the requirement		
					of participation or that correcti	ve	
		acility has a capacity			action was necessary.		
		d a census of 123 at					
	the time of th	is survey.					
	The Courts						
	The facility wa						
	· ·	th state law in					
		nkler coverage and					
	smoke detecto	or coverage.					
	All areas wher	e the residents have					
	customary acc						
	· -	Areas providing					
	· ·	s were sprinklered					
	lacility service	s were sprinklered					
	Ouality Review by	Robert Booher, Life Safety					
	1	edical Surveyor on 09/26/12.					
	_						
	The facility wa	s found not in					
	compliance wi	th the					
	aforemention						
		as evidenced by the					
	following:						

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Event ID: 5ZUI21

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PRINTED: 10/22/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMI 09/19	PLETED 9/2012	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ZUI21

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155747	B. WIN	G		09/19/	2012
	PROVIDER OR SUPPLIER			1300 M	NDDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	than required endopenings, exits, of substantial doors of 13/4 inch solid-becapable of resisting minutes. Doors in only required to resmoke. There is closing of the door with a means suit closed. Dutch dopermitted. 19.3 Roller latches are regulations in all I based on observite interview, the fensure 1 of 2 Aroom corridor of latched into the deficient practimost 4 resident Activity/Theraperiods included as a company of the control of the company of the control of th	corridor openings in other closures of vertical or hazardous areas are such as those constructed conded core wood, or ng fire for at least 20 in sprinklered buildings are easist the passage of no impediment to the core. Doors are provided cable for keeping the door core meeting 19.3.6.3.6 are 6.6.3 It prohibited by CMS health care facilities. revation and facility failed to activity/Therapy doors closed and it door frame. This is the could affect at the in the core meeting 19.3.6.3 are could affect at the core facilities. The could affect at the core facilities are activity for a could affect at the core facilities. The could affect at the core facilities are could affect at the core facilities. The could affect at the core facilities are facilities. The could affect at the core facilities are facilities and the core facilities. The could affect at the core facilities are facilities are facilities. The could affect at the core facilities are facilities are facilities. The could affect at the core facilities are facilities are facilities. The could affect at the core facilities are facilities are facilities. The could affect at the core facilities are facilities are facilities. The could affect at the could affect at the core facilities are facilities. The could affect at the could aff	K00	018	K018 It is the policy of this provider to provide positive latching devices as specificed NFPA 101. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The roller latch was replaced with a positive latchin device on September 20th. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: Other residents with the propensity to be affected by the alleged deficient practice were identified as those in the activi room. None were so identified What measures will be put into place or what systemic change will be made to ensure that the alleged deficient practice does	e ty 3.	09/20/2012

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	of Correction identification number: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 09/19/2012		
	PROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112		
	room did not have positive latching hardware. The right side door did latch into the frame but the left door required a key to deadbolt the door into the stationary right door. This was acknowledged by the Executive Director at the time of observation. 3.1–19(b)		not recur: The roller latch was replaced with a positive latchidevice on September 20th. The requirement is for a positive latching device - this action corrects the issue. Maintenant staff was in-serviced that rolled latches cannot be used in the SNF are of the complex. 4. In the corrective action will be monitored to ensure the defice practice will not recur i.e. what quality assurance program with put into place: The replacementation meets the regulation. Not further action would be required. 5. Completion date: September 20th, 2012.	ng he ce er low ient ut II be ent		

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLI	
		155747	B. WIN	G		09/19/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
111111111111111111111111111111111111111	NO VIDEN ON SOLVEN				MERCER AVE		
WOODC	REST NURSING C	ENTER		DECA	TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0038	NFPA 101						
SS=E	LIFE SAFETY CO	·					
		anged so that exits are at all times in accordance					
	with section 7.1.						
	Based on obser	vation and	K00	38	K038 It is the policy of this		10/01/2012
	interview, the f	acility failed to			provider to assure that exit		
	ensure the mea	ans of egress			access is arranged so that exi are readily available at all time		
	through 4 of 8	exits were readily			1. What corrective action will be		
	accessible for r	esidents without a			accomplished for those reside		
	clinical diagnos	sis requiring			found to have been affected b	<u>y</u> _	
	specialized sec	urity measures.			the deficient practice: The existing magnetic locks were		
	LSC 19.2.2.2.4 requires doors				replaced by "smart locks" which	ch	
	within a require	ed means of egress			allow the door to open after 15	5	
	shall not be eq	uipped with a latch			seconds of pressure on the	اما	
	or lock that red	uires the use of a			horizontal latching bar. It shou be noted that when the pressu		
	tool or key fror	n the egress side.			is placed on the bar, an alarm		
	Exception No.	l requires			activated. Signage was placed		
	door-locking a	rrangements			the exit doors as required. 2. I	<u>How</u>	
	without delayed	d egress shall be			other residents having the potential to be affected by the		
	permitted in he	ealth care			same alleged deficient practic		
	occupancies. o	r portions of health			will be identified and what		
	care occupanci	•			corrective action will be taken:	<u>.</u>	
	clinical needs o				Other residents with the propensity to be affected by the	ıe.	
	require special				alleged deficient practice were		
	measures for the	<u>-</u>			identified as those who neede		
		can readily unlock			use the emergency exits. Non	е	
	such doors at a	•			were so identified. The above correction allowed the doors to	,	
		ce could affect 50			open as required by NFPA 10		
	residents.	ce could uncer 50			What measures will be put into		
	i Coluello.				place or what systemic change		
	Findings includ	ام:			will be made to ensure that the		
	i i manigs metad	IC.			alleged deficient practice does not recur: The existing magne		
	Dagad an alar	مطغ طغنيي ممنعه			locks were replaced by "smart		
	Based on obser	vation with the			locks" which allow the door to		
			-				

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	OF CORRECTION OF CORRECTION 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 09/19/2012			
	PROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 during the tour from 12:07 p.m. to 2:15 p.m., both exit doors from A wing and C wing required a key to unlock and open the emergency exit doors. Based on an interview with Maintenance Technician # 1 at the time of observation, maintenance staff, nursing staff and unit managers are the only staff with a key to these exit doors. This was confirmed by the Executive Director during a phone conversation on 09/21/12 at 3:15 p.m. 3.1–19(b)		open after 15 seconds of pressure on the horizontal latching bar. It should be note that when the pressure is pla on the bar, an alarm is activa Signage was placed on the e doors as required. 4. How the corrective action will be monito ensure the deficient practic will not recur i.e. what quality assurance program will be puinto place: The replacement smart locks meet the requirer - no further action would be required. 5. Completion date October 1st, 2012.	ced ted. xit electored ce tut ment			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155747	B. WIN				
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CI	ENTER			TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0044	NFPA 101 LIFE SAFETY CO						
SS=E		f used, are in accordance					
	with 7.2.4. 19.2						
	Based on obse		K00)44	It is the policy of this provider t	to	10/19/2012
	interview, the f				assure that fire rated doors me		
		ets of fire barrier			the NFPA code requirements for		
					fire barriers. 1. What corrective		
	doors was prov				action will be accomplished for		
		e protection rating			those residents found to have been affected by the deficient	_	
		in which they are			practice: We believe the doors		
	installed. LSC	7.2.4 leads to LSC			meet the requirements but car		
	7.2.4.3.4 which	n requires openings			locate the necessary		
	in fire barriers	comply with LSC			documentation. A reputable		
	8.2.3.2.3.1 whi	ich requires 1 1/2			contractor was contacted to		
		2 hour fire barriers.			correct the issue. A bid was	0.40	
		practice could affect			obtained and accepted to remain and replace the doors and fran		
	-	the main dining			in question. The doors are on		
		the main uning			order and a copy of the contra	ct	
	room.				is attached (addendum #1). 2.		
		_			How other residents having the		
	Findings includ	le:			potential to be affected by the		
					same alleged deficient practice will be identified and what	<u> </u>	
	Based on an ob	servation with the			corrective action will be taken:		
	Executive Direc	tor, Maintenance			Other residents with the	•	
	Lead, Maintena	nce Technician # 1,			propensity to be affected by th	е	
		Services Supervisor			alleged deficient practice were	:	
	and Environme	•			identified as those using the		
		19/12 at 2:55 p.m.,			dining room. 3. What measur will be put into place or what	<u>es</u>	
	there was a two	• •			systemic changes will be made	e to	
	separation wall				ensure that the alleged deficie		
	-				practice does not recur: A		
	Healthcare and	•			reputable contractor was		
	_	ll contains a set of			contacted to correct the issue.		
	nonrated meta				bid was obtained and accepted remove and replace the doors		
	Maintenance To	echnician # 1			and frame in question. The do		
	confirmed the	separation wall was			are on order and a copy of the		

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PRINTED: 10/22/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733 (X5)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILDING 01	COMPLETED 09/19/2012			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DREFIY (EACH CORRECTIVE ACTION SHOULD BE	WOODC	PROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733				
CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO				
a two hour fire wall. 3.1–19(b) a two hour fire wall. 3.1–19(b) contract is attached (addendum #1). 4. How the corrective action will be monitored to ensure the deficient practice with review the summary from above and make recommendations based on the summaries for continued monitoring. 5. Completion date: October 19 th , 2012.	TAG	a two hour fire wall.	contract is attached #1). 4. How the conwill be monitored to deficient practice with what quality assurant will be put into place PI/QA&A Committee the summary from a make recommendat on the summaries for monitoring. 5. Committee #1.	(addendum rective action ensure the Il not recur i.e. nce program e: The e will review above and iions based or continued pletion date:			

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Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 01			COMPLETED	
		155747	B. WIN			09/19/	2012	
NAME OF P	ROVIDER OR SUPPLIER	• }		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-		
					IERCER AVE			
WOODCI	REST NURSING C	ENTER		DECAT	TUR, IN 46733			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG K0061	NFPA 101	LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE	
SS=C	LIFE SAFETY CO Required automa valves supervised	ODE STANDARD tic sprinkler systems have d so that at least a local when the valves are closed.						
	NFPA 72, 9.7.2.1							
	1. Based on ol	bservation and	K00	061	K0061It is the policy of this		10/05/2012	
	interview, the f	facility failed to			provider to maintain the control			
	ensure 1 of 1 p	oost indicator valves			valves for the fire suppression system (sprinkler) in a supervi			
	(PIV) was electi	ronically supervised.			condition. <u>1. What corrective</u>	.004		
	This deficient	practice affects all			action will be accomplished fo			
	occupants.				those residents found to have			
					been affected by the deficient practice: On October	_		
	Findings include:				5th, electronic supervision was	S		
					installed on the PIV and the 2	- 4"		
	Based on obse	rvation with the			gate valves supplying water to	the		
	Executive Direc	ctor, Maintenance			fire suppression system (sprinkler) for the facility. The			
	Lead, Maintena	ance Technician # 1,			chain locks were removed from	m		
	Environmental	Services Supervisor			the 2 - 4" gate valves. 2. How	<u>/</u>		
	and the Enviro	nmental Services			other residents having the			
	Trainee on 09/	19/12 at 2:25 p.m.,			potential to be affected by the same alleged deficient practic	_		
		dlocked in the open			will be identified and what	<u> </u>		
	position. No e	lectronic tamper			corrective action will be			
	-	served on the PIV.			taken: Other residents with the			
	This was confi				propensity to be affected by the alleged deficient practice were			
		ctor at the time of			identified as all. The correction			
	observation.				written in section #1, corrects			
					issue for all. 3. What measure	<u>es</u>		
	3.1-19(b)				will be put into place or what systemic changes will be mad	le to		
	- (/				ensure that the alleged deficie			
	2. Based on ob	servation and			practice does not recur: On			
	interview, the f	facility failed to			October 5th, electronic			
		vater valves for the			supervision was installed on the PIV and the 2 - 4" gate valves			
	sprinkler syste	m were			supplying water to the fire			
	-	supervised. This			suppression system (sprinkler) for		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETED			COMPLETED	
		155747	B. WIN			09/19/2012	
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3			ERCER AVE		
WOODCI	REST NURSING C	ENTER			UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	deficient pract	ice affects all			the facility. The chain locks we	ere	
	occupants.				removed from the 2 - 4" gate		
	•				valves. In addition, the supervision is tied into the fire		
	Findings include:				detection system, and upon		
				·	tampering, sets off an alarm.		
	December 1	and a state of			How the corrective action will be		
		rvation with the			monitored to ensure the deficie		
		ctor, Maintenance			practice will not recur i.e. what		
	Lead, Maintena	ance Technician # 1,			quality assurance program will	<u>be</u>	
	Environmental	Services Supervisor			put into place: The correction	_	
	and the Enviro	nmental Services			resolves the issue and require no further action. <u>5. Completion</u>		
	Trainee on 09	/19/12 at 12:53			date: October 5th, 2012.	<u> </u>	
		er shut off valves in			<u> </u>		
	the sprinkler ri						
	•						
		open position with					
	-	oadlock, however,					
	there was no e						
	supervision of	the valves. This					
	was confirmed	by the Executive					
	Director at the	time of					
	observation.						
	-						
	3.1-19(b)						
	J.1 13(b)						

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Event ID: 5ZUI21

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLET			ETED	
		155747	B. WIN			09/19/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODCI	REST NURSING CI	ENTER			TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=F	exercised under I	spected weekly and oad for 30 minutes per nce with NFPA 99.	K01	44	K0144 It is the policy of this		10/05/2012
	alarm annuncia readily observe personnel at a station such as NFPA 99, Healt 3-4.1.1.15 req annunciator, st	emergency s provided with an ator in a location ed by operating regular work s a nurses' station. th Care Facilities, uires a remote corage battery			provider to appropriately monit the generator and its function. What corrective action will be accomplished for those reside. found to have been affected by the deficient practice: A monitoring station was installe the nurses' station which is manned 24h/7d, as specified. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what	1. nts V. d at 2. e	
	operate outsideroom in a locate observed by operate a regular word annunciator should be conditions of the auxiliary power (a) Individual volumerating to sure the bar malfunctioning (b) Individual volumerationing (b) Individual volumerationing (b) Individual volumeration in a location in the sure operation in the bar malfunctioning (b) Individual volumeration in the sure operation in the sure	perating personnel ork station. The all indicate alarm the emergency or resource as follows: isual signals shall mergency or resource is upply power to load.			corrective action will be taken: Other residents with the propensity to be affected by the alleged deficient practice were identified as all. The corrective action described in section #1 resolves the issue for all. 3. Mineasures will be put into place what systemic changes will be made to ensure that the alleged deficient practice does not recommended. A monitoring station was install at the nurses' station which is manned 24h/7d, as specified. How the corrective action will is monitored to ensure the deficient practice will not recur i.e. what quality assurance program will put into place. The installation and placement of the monitoring station corrects the issue. No futher action is required. 5.	e //hat e or	

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Event ID: 5ZUI21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
		155747	B. WIN			09/19/2	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER			1300 M	ERCER AVE		
	REST NURSING C		DECATUR, IN 46733				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION DATE
IAG				IAG	Completion date: October 5 th	<u> </u>	DATE
	an engine-gen				2012.	',	
	condition shall						
	1. Low lubricating oil pressure.						
	2. Low water temperature.						
	3. Excessive water temperature.						
	4. Low fuel – when the main fuel						
	storage tank contains less than a						
	3-hour operating supply.						
	5. Overcrank (failed to start).						
	6. Overspeed.						
	Where a regular work station will						
	be unattended	periodically, an					
	audible and vis	sual derangement					
		riately labeled, shall					
		at a continuously					
	monitored loca						
		signal shall activate					
	_	e conditions in					
	· ·	and (b) occur but					
		ay these conditions					
	individually. T	=					
	· ·						
	practice could	affect all occupants.					
	Findings includ	de:					
	Based on an ol	oservation with the					
	Executive Direc	ctor, Maintenance					
		ance Technician # 1,					
		Services Supervisor					
		nmental Services					
		/19/12 at 1:10 p.m.,					
		generator did have					
	1	-					
	a remote annu	nciator paner					

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PRINTED: 10/22/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE S COMPLE 09/19/2	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	A trouble light annunciator pa	e main dining room. for the generator anel was located on wing. Neither ontinuously aff. This was he Executive						

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Event ID: 5ZUI21

Facility ID: 000556

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLI	ETED
		155747	B. WIN			09/19/2	2012
			Б. WПV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODCF	REST NURSING C	ENTER			TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0147	NFPA 101						
SS=C	LIFE SAFETY CO	·					
		ind equipment is in NFPA 70, National					
	Electrical Code. 9						
	Based on observation and		K01	47	K0147 It is the policy of this		09/19/2012
	interview, the facility failed to				provider to not use extension		
	ensure 1 of 1 flexible cords such				cords except as specified in th		
		n cord was not used			NFPA 101. 1. What corrective	-	
					action will be accomplished for those residents found to have		
	as a substitute for fixed wiring.				been affected by the deficient	-	
	LSC 9.1.2 requires electrical wiring				practice: The extension cord w		
	and equipment to comply with				removed from service in the		
	NFPA 70, Natio	nal Electrical Code,			presence of the surveyor on		
	1999 Edition.	NFPA 70, Article			September 19th. 2. How other		
	400-8 requires	, unless specifically			residents having the potential		
	permitted, flex	ible cords and			be affected by the same allege		
	cables shall no				deficient practice will be identified and what corrective action will		
		ixed wiring of a			taken: Other residents with the		
		deficient practice			propensity to be affected by th		
					alleged deficient practice were		
	could affect all	occupants.			identified as those using		
					extension cords. None were so)	
	Findings includ	le:			identified. The correction in section #1 resolves the issue f	·or	
					all. 3. What measures will be		
	Based on an ob	servation with the			into place or what systemic	10 0.0	
	Executive Direc	ctor, Maintenance			changes will be made to ensur	<u>re</u>	
		tenance Technician			that the alleged deficient pract		
	# 1 on 09/19/	12 at 12:55. a			does not recur: The extension		
		ension cord was			cord was removed from servic		
		providing power to			the presence of the surveyor of September 19th.4. How the)11	
		· · · · · · · · · · · · · · · · · · ·			corrective action will be monitor	ored	
	the spare comp				to ensure the deficient practice		
		room. Based on			will not recur i.e. what quality		
	interview with I				assurance program will be put	_	
	Technician # 1	at the time of			into place: The monthly		
	observation, th	e facility was not			inspection conducted by the		
			I		Environmental services		

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PRINTED: 10/22/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 09/19/2012
	PROVIDER OR SUPPLIER REST NURSING CENTER	1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	using the spare compressor at this time and removed the extension cord. 3.1–19(b)		department will be expended include ancillary service areas (i.e. the mechanical rooms). The monthly inspection includes looking for extension cords in in resident areas and immediataking them out of service. The results of the inspections shall communicated to the PI/QA&A committee by the Director of Environmental services, each month for 6 months. The PI/QA&A Committee will reviet the summary from above and make recommendations base on the summaries for continuem onitoring. 5. Completion date: September 19 th, 2012.	d ded

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Event ID: 5ZUI21

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Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLETE			COMPLETED	
		155747	B. WIN			09/19/2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		1300 MERCER AVE				
WOODCI	REST NURSING C	ENTER			TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	D	ATE
K0000							
		1 B .: 6: .:	17.00	000	Dana anatia		
	A Life Safety Code Recertification,		K00	000	Preparation and execution of this plan of	n	
	State Licensure	•			correction does not constitute		
	Assurance Wall	k-thru Survey were			admission or agreement by the		
	conducted by t	he Indiana State			provider of the truth of the fact	s	
	Department of	Health in			alleged or the conclusions set		
	accordance wit	h 42 CFR 483.70(a).			forth in the Statement of		
					Deficiencies rendered by the reviewing agency. The Plan of		
	Survey Date: 09/19/12				Correction is prepared and		
					executed solely because it is		
	Facility Number: 000556				required by the provisions of		
	Provider Numb				federal and state law. Woodci		
	AIM Number:			Nursing Center maintains that the alleged deficiencies do not		the	
	All Humber.	100230130			individually or collectively		
	Curiovori Ami	(Kallay Life Safety			jeopardize the health and/or th	e	
	-	Kelley, Life Safety			safety of its residents nor are t		
	Code Specialist	I .			of such character as to limit th	e	
					provider's capacity to render		
		ety Code survey,			adequate resident care. Furthermore, Woodcrest Nursi	na	
	Woodcrest Nur	sing Center was			Center asserts that it is in	iig	
	found not in co	ompliance with			substantial compliance with		
	Requirements	for Participation in			regulations governing the		
	Medicare/Medi	caid, 42 CFR			operation of long term care		
	Subpart 483.70	O(a), Life Safety			facilities, and this Plan of		
	<u> </u>	the 2000 edition of			Correction in its entirety constitutes this provider's		
	the National Fi				allegation of compliance and,		
		FPA) 101, Life Safety			thereby, we request resurvey t	o	
	•	1410 IAC 16.2. The			verify such as of October 19 th	,	
					2012.		
	Rehabilitation				Eusthan v	,	
		ing a rehabilitation			Further, v request desk review (paper	'E	
	_ ·	nt, nurses' station			compliance) for compliance, if		
	and offices was	s surveyed with			acceptable.		
	Chapter 18, Ne	w Health Care					
	Occupancies				Completion		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 09/19/2012				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION DATE			
	construction and sprinklered. The facility was compliance with a facility services. The facility services. The facility was compliance with a forementione.	be of Type V (111) nd was fully he facility has a fire with smoke rridors, areas open s with hard wired rs in the resident acility has a capacity d a census of 123 at s survey. s found in th state law in akler coverage and r coverage. e the residents have ess were reas providing s were sprinklered s found not in th the		dates are provided for processing purposes to co with federal and state regula and correlate with the most contemplated or accomplish corrective action. These do necessarily chronologically correspond to the date that Woodcrest Nursing Center i under the opinion that it was compliance with the require of participation or that correaction was necessary.	mply ations, recent ned not s s in ments			
				ĺ				

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Event ID: 5ZUI21

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLETED			COMPLETED
		155747	B. WIN			09/19/2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				IERCER AVE	
WOODC	REST NURSING C	ENTER			UR, IN 46733	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
K0061 SS=C	valves supervised	tic sprinkler systems have d so that at least a local when the valves are closed.				
	Based on observation and interview, the facility failed to		K00	061	K0061It is the policy of this	10/05/2012
					provider to maintain the contro	
	ensure 1 of 1 p	oost indicator valves			valves for the fire suppression system (sprinkler) in a supervi	
	(PIV) was electronically supervisor.				condition. 1. What corrective	seu
	This deficient practice affects all				action will be accomplished for	<u>r</u>
	occupants.				those residents found to have	
	Findings include:				been affected by the deficient practice: On October 5th, electronic supervision was installed on the PIV and the 2	6 - 4"
	Based on obse	rvation with the			gate valves supplying water to	the
	Executive Direc	ctor, Maintenance			fire suppression system	
		nce Technician # 1,			(sprinkler) for the facility. The chain locks were removed from	n
	•	Services Supervisor			the 2 - 4" gate valves. 2. How	
		nmental Services			other residents having the	
					potential to be affected by the	
		19/12 at 2:25 p.m.,			same alleged deficient practice	<u>e</u>
	· ·	dlocked in the open			will be identified and what corrective action will be	
	⁻	lectronic tamper			taken: Other residents with the	
		erved on the PIV.			propensity to be affected by th	
	This was confi	•			alleged deficient practice were	
	Executive Direct	ctor at the time of			identified as all. The correction	
	observation.				written in section #1, corrects	
					issue for all. 3. What measure will be put into place or what	<u> </u>
	3.1-19(b)				systemic changes will be mad	e to
					ensure that the alleged deficie	
	2. Based on ob	servation and			practice does not recur: On	
	interview, the f	facility failed to			October 5th, electronic	
		vater valves for the			supervision was installed on the	
	sprinkler syste				PIV and the 2 - 4" gate valves	
	'	III were			supplying water to the fire suppression system (sprinkler) for

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		155747			09/19/2012
		A. BUILDING B. WING STREET 1300 M	ADDRESS, CITY, STATE, ZIP CODE MERCER AVE TUR, IN 46733 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) the facility. The chain locks we removed from the 2 - 4" gate valves. In addition, the supervision is tied into the fire detection system, and upon tampering, sets off an alarm. 4 How the corrective action will monitored to ensure the deficit practice will not recur i.e. what quality assurance program will put into place: The correction resolves the issue and require no further action. 5. Completic	COMPLETED 09/19/2012 (X5) COMPLETION DATE Pere	
	Trainee on 09, p.m., both wat the sprinkler recurred in the a chain and a there was no esupervision of	/19/12 at 12:53 for shut off valves in liser room were liser position with padlock, however, electronic liser the valves. This		no further action. <u>5. Completi</u> date: October 5th, 2012.	

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155747	B. WIN			09/19/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CI	ENTER	DECATUR, IN 46733				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG K0143	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=E	LIFE SAFETY CO	ODE STANDARD					
00-L	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating						
	•	s occurring, and that					
	•	mediate area is not					
	the Compressed	rdance with NFPA 99 and					
	8.6.2.5.2	Gas Association.					
	Based on obse	rvation and	K0143		K0143 It is the policy of this		10/05/2012
	interview, the f	acility failed to			provider to sprinklered,		
	ensure 1 of 2 c	-			mechanically ventilated oxyge		
		was separated by			storage. <u>1. What corrective ac</u> will be accomplished for those		
	-	ith a one hour fire			residents found to have been	_	
	resistant rating	j. NFPA 99,			affected by the deficient		
	_	uires storage for			<u>practice:</u> The self closing mechanism on the door to the		
	-	gases shall comply			oxygen room lacked sufficient		
	with 4-3.1.2.	· ·			mechanical advantage to latch		
		quires at least one			the door. The door closer was		
		ant enclosures shall			replaced with a stronger mechanical self closer, which i	2014	
		r the storage of			allows the door to close and to		
		ts such as oxygen.			latch as required. 2. How other		
	Furthermore, s				residents having the potential		
	hazardous area				be affected by the same alleged deficient practice will be identified.		
		e room are required			and what corrective action will		
		l with self closing			taken: Other residents with the		
		door is required to			propensity to be affected by th	е	
	addis and the	addi is required to			alleged deficient practice were		

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CONSTRI A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2012			
	PROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CRE TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	latch. This deficient practice could affect 10 residents on the Extended Care wing. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 1:40 p.m., the door to the oxygen manifold room for the piped in oxygen on the Extended Care Wing did self close but failed to latch into the door frame. Based on an interview with the Maintenance Technician # 1 at the time of observation, this is a problem due to the required mechanical ventilation and negative air flow in the room. 3.1–19(b)	the sect all. into cha that doe was med allo late correto e will ass into clos furti	ntified as those resideing or ECU. The correction in ECU. The surface or what systemic enges will be made to ensure the alleged deficient practices replaced with a stronger chanical self closer, which rows the door to close and to the as required. A. How the exercive action will be monitour the deficient practice of the end	or out re ice er now ored e			

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLE			ETED	
		155747	B. WIN			09/19/2	2012
			р. WIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODCF	REST NURSING C	ENTER	DECATUR, IN 46733				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144	NFPA 101						
SS=F	LIFE SAFETY CO						
		spected weekly and					
	exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.						
	Based on observation and		K01	11	K0144 It is the policy of this		10/05/2012
			IXO		provider to appropriately monit	tor	10/03/2012
	interview, the f	•			the generator and its function.		
	ensure 1 of 1 e	- ·			What corrective action will be		
	_	provided with an			accomplished for those reside		
	alarm annunciator in a location				found to have been affected by	<u>v</u>	
	readily observed by operating				the deficient practice: A monitoring station was installe	d of	
	personnel at a	regular work			the nurses' station which is	u ai	
	station such as	a nurses' station.			manned 24h/7d, as specified.	2.	
	NFPA 99, Healt	h Care Facilities,			How other residents having the		
	3-4.1.1.15 req				potential to be affected by the	-	
	annunciator, st				same alleged deficient practice	<u>e</u>	
	powered, shall	- ·			will be identified and what		
	•	e of the generating			corrective action will be taken: Other residents with the		
	=	-			propensity to be affected by th	e l	
	room in a locat	•			alleged deficient practice were		
		perating personnel			identified as all. The corrective	;	
	-	rk station. The			action described in section #1		
	annunciator sh	all indicate alarm			resolves the issue for all. 3. V		
	conditions of tl	he emergency or			measures will be put into place what systemic changes will be		
	auxiliary power	r source as follows:			made to ensure that the allege		
	(a) Individual vi	isual signals shall			deficient practice does not rec		
	indicate:				A monitoring station was instal		
	1. When the en	nergency or			at the nurses' station which is		
		· ·			manned 24h/7d, as specified.		
	auxiliary power				How the corrective action will I		
	· ·	ipply power to load.			monitored to ensure the deficient practice will not recur i.e. what		
		ttery charger is			quality assurance program will		
	malfunctioning				put into place: The installation		
	(b) Individual v	isual signals plus a			and placement of the monitoring		
	common audib	le signal to warn of			station corrects the issue. No		
		-			futher action is required.5.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	02	COMPL	
		155747	B. WIN	G		09/19/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	FRO VIDER OR SUFFLIER		1300 MERCER AVE				
WOODC	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	an engine-gen				Completion date: October 5 th , 2012.		
	condition shall indicate:				2012.		
	1. Low lubricat	ting oil pressure.					
	2. Low water to	emperature.					
	3. Excessive w	ater temperature.					
	4. Low fuel – when the main fuel						
	storage tank contains less than a						
	3-hour operating supply.						
	5. Overcrank (failed to start).						
	6. Overspeed.						
	Where a regular work station will						
	_	periodically, an					
		sual derangement					
		riately labeled, shall					
	1	at a continuously					
	monitored loca	<u>-</u>					
		signal shall activate					
	_	ne conditions in					
	I	and (b) occur but					
		ay these conditions					
	individually. T	·					
	I						
	practice could	affect all occupants.					
	Findings includ	de:					
	Based on an ol	oservation with the					
		ctor, Maintenance					
		ance Technician #1,					
	1	Services Supervisor					
		nmental Services					
		/19/12 at 1:10 p.m.,					
	·	•					
		generator did have					
	a remote annunciator panel						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CC A. BUILDING B. WING	02	COMI	COMPLETED 09/19/2012	
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER			1300 M	ADDRESS, CITY, STATE, ZIP ERCER AVE 'UR, IN 46733	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	A trouble light annunciator pa	e main dining room. for the generator anel was located on wing. Neither ontinuously aff. This was he Executive				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	02	COMPLETED	
		155747	B. WIN	G		09/19/2012	
NAME OF D	DOWNDER OF STIPPTIED		•	STREET.	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER				1300 N	IERCER AVE		
			DECATUR, IN 46733				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG				TAG	DEFICIENCY)	DATE	
K0147	NFPA 101						
SS=C	LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National						
	Electrical Code. 9						
	Based on obse		K01	K0147 K0147 It is the policy		09/19/2012	
	interview, the f	acility failed to			provider to not use extension		
		lexible cords such			cords except as specified in th	I	
	as an extension cord was not used				NFPA 101. 1. What corrective		
		for fixed wiring.			action will be accomplished for those residents found to have		
		ires electrical wiring			been affected by the deficient	-	
					practice: The extension cord	-	
	• •	to comply with			removed from service in the		
	•	nal Electrical Code,			presence of the surveyor on		
		NFPA 70, Article			September 19th. 2. How other		
	400-8 requires	s, unless specifically			residents having the potential be affected by the same alleg		
	permitted, flex	ible cords and			deficient practice will be ident		
	cables shall no	t be used as a			and what corrective action wil		
	substitute for f	ixed wiring of a			taken: Other residents with the		
	structure. This	deficient practice			propensity to be affected by the		
	could affect all	occupants.			alleged deficient practice were identified as those using	e	
		·			extension cords. None were s	80	
	Findings includ	le:			identified. The correction in		
	i mamga merae	C.			section #1 resolves the issue	for	
	Pacad on an ob	scaruation with the			all. 3. What measures will be	e put_	
	Based on an observation with the Executive Director, Maintenance				into place or what systemic	150	
					changes will be made to ensure that the alleged deficient prac		
		tenance Technician			<u>does not recur:</u> The extension		
	# 1 on 09/19/				cord was removed from service		
	heavy duty ext	ension cord was			the presence of the surveyor	on	
	plugged in a pi	roviding power to			September 19th. <u>4. How the</u>		
	the spare comp	oressor in the			corrective action will be monit		
	sprinkler riser	room. Based on			to ensure the deficient practic will not recur i.e. what quality		
	interview with	Maintenance			assurance program will be pu	-	
	Technician # 1	at the time of			into place: The monthly		
	observation, the facility was not				inspection conducted by the		
	Josef Vacion, th	ic facility was not			Environmental services		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747	A. BUILDING B. WING	COMPLETED 09/19/2012			
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733 ID PROVIDER'S PLAN OF CORRECTION (X.5)				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
using the spare compressor at this time and removed the extension cord. 3.1–19(b)	department will be expended include ancillary service area (i.e. the mechanical rooms). monthly inspection includes looking for extension cords ir in resident areas and immed taking them out of service. The results of the inspections shad communicated to the PI/QA8 committee by the Director of Environmental services, each month for 6 months. The PI/QA&A Committee will revit the summary from above and make recommendations base on the summaries for continumonitoring. 5. Completion date: September 19 th, 2012	nuse diately the d			

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